**INSTRUCTIONS FOR RATE TRANSMITTAL FORM**
**MEDICARE SUPPLEMENT**

Please refer to the following instructions when completing the transmittal form. You are permitted to reproduce this form on a PC as long as the produced form is substantially the same.

**SECTION 1**

**Company OCI Number** - ***Do not use NAIC Number.*** This is usually the company's federal tax identification number. It can be obtained by calling our Bureau of Financial Examinations at (608) 266-0091.

**Submission Number**—Leave blank.

**Company Name and Mailing Address**—Name and address of the company making the filing.

**Contact Person**—Name of the person responsible for the rate filing.

**Telephone Number**—Telephone number of the contact person. Include the area code and extension number, if applicable.

**Total Overall Rate Change**—Show the average rate change considering all forms rounded to one decimal place. Show "N/A" for new form filings.

**Effective Date**—The effective dates of the rates. If the effective date for renewal business is different from the effective date for new business, use the new business effective date. Enter the date in numerals using the format MM/DD/YYYY.

**Product Category, Alpha Code**—A list of product categories and alpha codes is included in this packet. These codes are the same as used for form filings.

**SECTION 2**

**Coverage**—For all forms issued prior to January 1, 1992, please enter the type of coverage involved (Base Policy, Part A Ded. Rider, etc.).

**Form Number**—List the form number of each form addressed in the filing that has separate rates.

**Rate Change**—Show the overall rate change for each form rounded to one decimal place. If the rate change does not affect all forms equally (for example: different percent changes for different ages or different rating areas), report the average statewide change.

For new forms, show "N/A."

**Form Approval Date**—Indicate the date each form was approved for use in Wisconsin. For initial rate filings, show "N/A."

# Medicare Supplement Product Categories and Codes

| Product Category<br>Product Codes | Description |
|---|---|
| **Group Accident & Health** | |
| MDC | Medicare cost |
| MER | Medicare risk |
| MDS | Medicare select |
| MSP | Medicare supplement |
| **Health Maintenance Organizations (HMO)** | |
| GMC | Group/Medicare cost |
| GMR | Group/Medicare risk |
| GMS | Group/Medicare select |
| IMC | Individual/Medicare cost |
| IMR | Individual/Medicare risk |
| IMS | Individual/Medicare select |
| **Individual Accident & Health** | |
| MDC | Medicare cost |
| MER | Medicare risk |
| MDS | Medicare select |
| MSP | Medicare supplement |
| **Preferred Provider Plan (PPP)** | |
| GMC | Group/Medicare cost |
| GMR | Group/Medicare risk |
| GMS | Group/Medicare select |
| IMC | Individual/Medicare cost |
| IMR | Individual/Medicare risk |
| IMS | Individual/Medicare select |

**RATE TRANSMITTAL FORM**
**MEDICARE SUPPLEMENT**

**Ref:** Section 601.42 and ch. 625, Wis. Stat.
Sections Ins 3.13 and 3.39 (4) (g), Wis. Adm. Code

State of Wisconsin
Office of the Commissioner of Insurance
Bureau of Market Regulation
P. O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-3585

**PLEASE REFER TO INSTRUCTIONS WHEN COMPLETING FORM.** The instructions may be obtained from the Insurance Commissioner's Office at the above address.

**SECTION 1**

| | |
|---|---|
| Company OCI Number | **FOR OCI USE ONLY** Submission Number |
| Company Name and Mailing Address | Contact Person |
| | Contact Person's Telephone Number |
| | Total Overall Rate Change / Effective Date |
| Product Category | Product Code |

**SECTION 2**

| | Form Number | Rate Change | Form Approval Date |
|---|---|---|---|
| **Coverage (Issues of 1/1/92 and later)** | | | |
| Base Policy | | ____ . ___ % | |
| Part A Deductible Rider | | ____ . ___ % | |
| Part B Deductible Rider | | ____ . ___ % | |
| Part B Excess Rider | | ____ . ___ % | |
| Prescription Drug Rider | | ____ . ___ % | |
| Home Health Rider | | ____ . ___ % | |
| Foreign Travel Rider | | ____ . ___ % | |
| **Coverage (Issues Prior to 1/1/92)** | | | |
| | | ____ . ___ % | |
| | | ____ . ___ % | |
| | | ____ . ___ % | |
| | | ____ . ___ % | |
| | | ____ . ___ % | |
| | | ____ . ___ % | |
| | | ____ . ___ % | |
| | | ____ . ___ % | |
| | | ____ . ___ % | |

**FOR OCI USE ONLY**

**DATE FILED:** _____ **INITIALS:** _____